REQUEST FOR APPLICATIONS **RFA # 2010-261**

TITLE: 1915 (b)/(c) Medicaid Waiver Expansion

FUNDING AGENCY: North Carolina Department of Health and Human Services, Division of Medical Assistance

ISSUE DATE: Thursday, February 18, 2010

FUNDING AGENCY: DHHS, Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
Attn: Sherry Cannady, DMA Contracts Office

IMPORTANT NOTE: Indicate agency or organization name and RFA number on the front of each application envelope or package, along with the date for receipt of applications specified below.

Applications, subject to the conditions made a part of hereof, will be received until 5:00 p.m., Wednesday, April 14, 2010, for furnishing services described herein.

SEND ALL APPLICATIONS DIRECTLY TO THE FUNDING AGENCY ADDRESS SHOWN ABOVE.

Direct all inquiries concerning this RFA to the attention of:

Judy Walton	and	Ken Marsh
NC Division of Medical Assistance		NC DMH/DD/SAS
RFA.Medicaidwaiver@dhhs.nc.gov		RFA.Medicaidwaiver@dhhs.nc.gov

NOTE: Questions concerning the specifications in this Request for Applications will be received until 5:00 p.m., Thursday, March 4, 2010. Such questions should be directed via email to RFA.Medicaidwaiver@dhhs.nc.gov or be asked at the Bidders Conference.

A summary of all questions and answers will be posted by Wednesday, March 10, 2010, on the websites of the Division of Medical Assistance at: http://www.ncdhhs.gov/dma/lme/MHWaiver.htm and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services at: http://www.ncdhhs.gov/mhddsas/waiver/index.htm

All prospective applicants are encouraged to attend the Bidders Conference that will involve a presentation about the RFA and provide the opportunity to ask questions. The Bidder's Conference will be held on Thursday, March 4, 2010 from 2 p.m. to 5 p.m. See the websites noted above for additional information and directions to the location.

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INTRODUCTION

The North Carolina Department of Health and Human Services (DHHS) is initiating this request for applications (RFA) to solicit applications from local management entities (LMEs) to operate Medicaid funded services through capitated Pre-paid Inpatient Health Plans (PIHP). DHHS will select and contract with one or more qualified LME applicants that meet the Centers for Medicare and Medicaid Services (CMS) and DHHS regulatory and technical criteria, as well as industry standards for the administrative, clinical and financial operations of a PIHP. The requirements and criteria for participation in the waiver program are specified in this RFA. DHHS anticipates announcement of the selected LME(s) by July 2010.

In April 2005, DHHS began operating under two new waivers as a pilot project: (1) the Piedmont Cardinal Health Plan, a pilot 1915 (b) Freedom of Choice waiver project; and (2) the Innovations Home and Community Based services (HCBS) 1915 (c) waiver. In this pilot project, Medicaid funded services for mental health, substance abuse and developmental disabilities are provided on a capitation basis in a five-county area through a PIHP. PBH (formerly known as Piedmont Behavioral Healthcare), a local management entity (LME), operates the PHIP and manages state funded mental health, substance abuse and developmental disabilities services.

DHHS has elected to expand the pilot project beyond PBH to be phased in statewide. Toward this goal, DHHS submitted waiver amendment requests to CMS in December 2009 to expand the pilot project through modification of the existing Piedmont Cardinal Health Plan 1915(b) Freedom of Choice waiver, and modification of the 1915(c) Innovations Home and Community Based Services (HCBS) waiver. Waiver amendments are available for review on the DHHS Division of Medical Assistance (DMA) website at: http://www.ncdhhs.gov/dma/lme/MHWaiver.htm.

The two contracts resulting from this RFA will be administered by DHHS Division of Medical Assistance (DMA) and the DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The selected LME(s) will continue current obligations and commitment to the management of state funded mental health, substance abuse and developmental disabilities services as specified in a newly defined DMH/DD/SAS-LME performance contract in its entirety as attached to this RFA.

LMEs that apply under this RFA and are not selected or LMEs that choose not to apply will continue to operate under the rules and regulations governing the existing Medicaid fee-for-service program and will continue to oversee state funded mental health, substance abuse, and developmental disabilities services under the DHHS-DMH/DD/SAS performance contract. LMEs will have future opportunities to apply to operate a PIHP as North Carolina and CMS plan the State's waiver expansion.

Acronyms

CFR	Code of Federal Regulations
CMS	The federal Centers for Medicare and Medicaid Services http://www.cms.hhs.gov/
DD or I/DD	Developmental disabilities or intellectual and/or developmental disabilities
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance, a division of DHHS and North Carolina's State Medicaid Agency
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities and Substance Abuse Services, a division of DHHS

HCBS	Home and Community Based Services
HIPAA	*Health Insurance Portability and Accountability Act* enacted by the U.S. Congress in 1996
ICF-MR	Intermediate Care Facility for the Mentally Retarded
PBH	The LME formerly named Piedmont Behavioral HealthCare
PIHP	Prepaid Inpatient Health Plan – see below
PMPM	Per member per month
UM/UR	Utilization management / utilization review – see below

Definitions

Action	The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the LME to act within the timeframes provided in 42 C.F.R. 438.408(b). For a rural area resident with only one LME, the denial of a Medicaid Enrollee's request to obtain services outside the Provider Network: a. From any other provider in terms of training, experience, and specialization) not available in the network. b. From a provider not part of the network that is the main source of a service to the recipient—provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the Enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days. c. Because the only plan or provider available does not provide the service because of moral or religious objections. d. Because the Enrollee's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.
Appeal	A request for administrative review of an Action as defined above.
Grievance and Appeal Procedure	The written procedures pursuant to which Enrollees may express dissatisfaction with the provision of services by the LME and the methods for resolution of Enrollee grievances and appeals by the LME.
Capitation Payment	A fixed payment remitted at regular intervals by DMA to the LME(s) operating a PIHP. The LME determines whether their providers are paid fee for service or on a capitated basis.
Care Management	A multidisciplinary, disease centered approach to managing medical care using outcome measures to identify best practices. The purpose of care management is to identify level of risk, stratify of services

	according to risk, and prioritize recipients for services. The approach utilizes collaboration of services, systematic measurement and reporting and resource management.
Clean Claim	A clean claim is a claim that can be processed without obtaining additional information from the provider of the services or from a third party. It does not include a claim under review for medical necessity, or a claim that is from a provider that is under investigation by a governmental agency for fraud or abuse.
Complaint	See grievance.
Covered Services	The services identified in the waiver application and in the contract that the LME agrees to manage pursuant to the terms of the contract.
Cultural Competency	The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of mental health, developmental disabilities and substance abuse services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.
Days	Unless otherwise noted, refers to calendar days. "Working day" or "business day" means day on which DHHS is officially open to conduct its affairs.
Department	The North Carolina Department of Health and Human Services
Enrollee	A person who is on Medicaid and in one of the mandatory eligibility groups included in the waiver is automatically enrolled in the PIHP regardless of whether s/he ever accesses services.
Evidence based	A program or practice that has had multiple site random controlled trials demonstrating that the program or practice is effective for the population served.
Fee-for-service	A method of making payment directly to health care providers enrolled in the Medicaid program for the provision of health care services to Recipients based on the payment methods set forth in the State Plan and the applicable policies and procedures of DMA.
Grievance	An expression of dissatisfaction by or on behalf of an Enrollee about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the LME level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee’s rights).

Hearing	A formal proceeding before an Office of Administrative Hearing Law Judge in which parties affected by an action or an intended action of DHHS shall be allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.
Innovations Waiver	The current NC 1915 C home and community based services waiver (HCBS) currently operated by PBH and for which application has been made for statewide implementation. The Innovations Waiver replaces the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD) in the Piedmont counties.
Insolvency	The inability of the LME to pay its obligations.
Medical Necessity	Treatment that is a. Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition; b. Consistent with Medicaid policies and National or evidence based standards, North Carolina Department of Health and Human Services defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided; c. Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care; d. Not provided solely for the convenience of the recipient, recipient's family, custodian or provider; e. Not for experimental, investigational, unproven or solely cosmetic purposes; f. Furnished by or under the supervision of a practitioner licensed (as relevant) under State law in the specialty for which they are providing service and in accordance with Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies, and other applicable Federal and state directives; g. Sufficient in amount, duration and scope to reasonably achieve their purpose, and h. Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment. Within the scope of the above guidelines, medically necessary treatment shall be designed to: a. Be provided in accordance with a person centered service plan which is based upon a comprehensive assessment, and developed in partnership with the individual (or in the case of a child, the child and the child's family or legal guardian) and the

	community team; b. Conform with any advanced medical directive the individual has prepared; c. Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and d. Prevent the need for involuntary treatment or institutionalization.
Network Provider	A provider of mental health, developmental disabilities and substance abuse services that meets the LME's criteria for enrollment, credentialing and/or accreditation requirements and has signed a written agreement to provide services
Prepaid Inpatient Health Plan (PIHP)	An entity that 1) provides medical services to Enrollees under contract with the State Medicaid agency; 2) on the basis of prepaid capitation payments or other payment arrangements does not use State plan payment rates; 3) provides arranges for or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and 4) does not have a comprehensive risk contract.
Prior authorization	The act of authorizing specific services before they are rendered.
Provider	Any person, agency or entity providing mental health, developmental disabilities, or substance abuse services.
Provider Network	The agencies, professional groups, or professionals under contract to the LME that meet LME standards and that provide authorized Covered Services to eligible and enrolled persons
Recipient	An Enrollee who is receiving services.
Reconsideration	An enrollee's first step in the appeal process after an adverse organization determination; the waiver entity shall have procedures to reevaluate an adverse organization determination, findings upon which it was based, and any other evidence submitted or obtained.
Recovery	The processes by which people are able to live, work, learn and participate fully in their communities.
Resilience	The personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives.
Risk Contract	A contract under which the contractor: 1) assumes risk for the cost of the services covered under the contract; and 2) incurs loss if the cost of furnishing the services exceeds the payments under the contract. This contract is a risk contract because the LME assumes that risk that the cost of providing Covered Services to Enrollees may exceed the capitation rate paid by DHHS.
Risk Reserve	A restricted reserve account maintained by the LME to fund payments for outstanding obligations, such as cost overruns related to Medicaid program services.
Self-determination	Self-determination refers to the right of individuals to have full

	power over their own lives, regardless of presence of illness or disability. Self-determination in the mental health system refers to individuals' rights to direct their own services, to make the decisions concerning their health and well-being (with help from others of their choice, if desired), to be free from involuntary treatment, and to have meaningful leadership roles in the design, delivery, and evaluation of services and supports.
Service Management Record	A record of Enrollee demographics, authorizations, referrals, actions and services billed by Network Providers
State	The State of North Carolina
State Plan	The "State Plan" submitted under Title XIX of the Social Security Act, Medical Assistance Program for the State of North Carolina and approved by CMS
Subcontract	An agreement which is entered into by the LME in accordance with Section 11
Subcontractor	Any person or entity which has entered into a contract with the LME.
Third Party Resource	Any resource available to a Member for payment of expenses associated with the provision of Covered Services (other than those which are exempt under Title XIX of the Act), including but not limited to, insurers, tort-feasors, and worker's compensation plans
Utilization Management (UM)	A system's overall strategy for managing service utilization by individual clients and by the system as a whole. UM is implemented through a plan that combines care management, resource management, UR, and uses financial data to determine trends and service use patterns
Utilization Review (UR)	The process used to evaluate requested health care services and determine whether they are medically necessary
Waiver	The document by which DHHS, DMA, requests sections of the Social Security Act (SSA) be waived, in order to operate a capitated managed care system to provide services to enrolled recipients. Section 1915 (b) of the SSA authorized the Secretary to waive the requirements of sections 1902 of the SSA to the extent he or she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost-effective, efficient, and consistent with the objectives of the Medicaid program. Section 1915 (c) of the SSA provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings as the Medicaid alternative to providing comprehensive long-term services in institutional settings. Initial waivers are approved for three years. Renewed waivers are granted for five years.
Waiver Entity	An LME, that alone or in a group configuration, meets the selection criteria and passes readiness reviews to operate North Carolina's 1915 (b) and (c) waiver in a given geographic catchment area

BACKGROUND

In 2009, the Department of Health and Human Services (DHHS) initiated a collaborative effort with the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) with the goal of restructuring the delivery system for Medicaid funded mental health, substance abuse and developmental disabilities services. The new delivery system will operate on a capitation basis and will be phased in statewide.

DMA manages North Carolina's Medicaid health insurance program for low-income individuals and families including parents, children, seniors, and people with disabilities. The Medicaid program includes coverage of mental health, developmental disabilities and substance abuse services.

DMH/DD/SAS has specific responsibilities for the provision of publicly funded services for individuals in the State with mental health and substance abuse problems and/or with developmental disabilities. Furthermore, DMH/DD/SAS is responsible for the programmatic oversight of the use of funds allocated by the General Assembly for these purposes, including those provided by federal block grants.

At the local level, the DMH/DD/SAS oversees mental health, developmental disabilities and substance abuse services through a network of area authorities / county programs that cover the state's 100 counties. As a result of system reform undertaken in 2001, the role of area authorities / county programs changed from service provider to service manager as they became local management entities (LMEs). LMEs develop community capacity through service provider contracts, expand partnerships with formal and informal community organizations and engage individuals with disabilities in planning and policy implementation. Most services are now provided through the private sector.

In the process of reform, DHHS established one LME as a pilot project through the use of 1915(b) and 1915(c) Medicaid waivers to serve individuals with mental health, developmental disabilities and substance abuse needs who are eligible for Medicaid. While remaining responsible for state allocated funds including federal block grants and for all applicable rules and policies, PBH (formerly known as Piedmont Behavioral Health) began delivering Medicaid State Plan funded mental health and substance abuse services through the Piedmont Cardinal Health Plan, a capitated model known as a prepaid inpatient health plan (PIHP). PBH also began delivering Home and Community Based Services and supports through the Innovations waiver, a 1915(c) waiver for individuals with mental retardation or developmental disabilities. The Innovations waiver replaced the State's Comprehensive and Supports waivers in the PBH catchment area. Accordingly, PBH assumed risk for mental health and substance abuse services (including inpatient, clinic option and rehabilitation option services) through the Piedmont Cardinal Health Plan, and for Home and Community Based Services under the Innovations waiver.

The waivers have operated in the five PBH counties since April 1, 2005. All Medicaid recipients in those counties that are included in eligibility groups covered under the 1915 (b)/(c) waiver were mandatorily enrolled with PBH operating the single PIHP on April 1, 2005.

Since the inception of these waiver programs, North Carolina has demonstrated that the State can provide quality mental health, developmental disabilities and substance abuse services through private and public sector cooperation and at a lesser or comparable cost than the fee-for-service (FFS) program costs for the Medicaid eligible population.

In 2009, DHHS elected to expand the 1915 (b)/(c) Medicaid waiver statewide with the intent to establish one or more additional LMEs operating both waivers through a PIHP. This RFA establishes the requirements for a LME to operate a PIHP. Upon the approval of CMS, DHHS will select and contract with one or more LME(s) to operate Medicaid funded services through a capitated PIHP.

Goals for North Carolina

DHHS has three primary goals for the statewide expansion of the 1915 (b)/(c) Medicaid waiver, including:

- Improved access to services.
- Improved quality of all services.
- Improved cost benefit.

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The performance of the system will be measured over the long term as LMEs operating a PIHP are included in the 1915 (b)/(c) Medicaid waiver to determine how well the strategy meets these primary goals for North Carolina.

SCOPE OF WORK

If approved for participation in North Carolina's 1915 (b)/(c) Medicaid waiver program, an LME will be eligible to enter into a contract with DMA to operate a prepaid inpatient health plan (PIHP) for the delivery of Medicaid covered mental health, developmental disabilities and substance abuse services. LMEs operating a PIHP will be responsible for complying with all terms and conditions of a contract between the Division of Medical Assistance and the Local Management Entity (referred to as the DMA Contract), including but not limited to: recruiting and credentialing providers, developing and overseeing a comprehensive MH/DD/SAS provider network that assures timely access to services for all enrollees, authorizing payments for services, processing and paying claims, and conducting care management, utilization management and quality management functions. DMA will pay each participating LME per member/per month (PMPM) capitated payments. See the attached sample DMA Contract for a delineation of all requirements and agreements.

LMEs must also comply with the contract between the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Local Management Entity (referred to as the DMH/DD/SAS Contract) in its entirety. See the attached sample DMH/DD/SAS Contract. Note DMHDDSAS contract reflects the same format as DHHS-LME performance contract while complementing the enhanced roles and responsibilities of an LME operating a PIHP.

For the purposes of the DMA Contract, Medicaid covered services are enhanced mental health and substance abuse services, inpatient services, outpatient services, psychiatric residential treatment facilities, residential treatment services, and intermediate care facilities for individuals with mental retardation, as defined in DMA clinical coverage policies 8A through 8E. Clinical coverage policies are located on the DMA website at: http://www.dhhs.state.nc.us/dma/mp/index.htm. In addition, Medicaid covered services under this contract include Innovations waiver services and 1915(b)(3) services as defined in the Innovations 1915 (c) waiver and the 1915(b) Medicaid waiver. See the 1915(b)/(c) waivers and waiver amendments posted on the DMA and the DMH/DD/SAS websites.

Enrollment in the PIHP will be mandatory for every Medicaid recipient whose county of residence for Medicaid purposes is located in the geographic area covered by the PIHP. See attachment J of the DMA Contract. Enrollment of Medicaid recipients will be automated through DMA's Medicaid Management Information System.

The capitation rates paid each month by DMA for each Medicaid recipient residing in the covered geographic coverage area, including retroactive payments and adjustments, are considered payment in full for all services to be provided under the DMA Contract, including all administrative costs. These rates will be certified as compliant with the Centers for Medicare and Medicaid Services (CMS) requirements under 42 C.F.R. 438.6(c) by actuaries meeting the standards of the American Academy of Actuaries. The State will request approval from CMS to add an additional 2% to the monthly capitation payment to begin funding the risk reserve account. Refer to Section 10 of the Statement of Work of the DMA Contract for more information on capitated payments and Attachment Q for a description of the rate-setting methodology.

For consideration as an applicant for operating a PIHP, the LME must understand and be prepared to comply with the DMA Contract in its entirety, as well as respond to the particular requests for information as outlined in this RFA. Submission of an application in response to this RFA indicates

agreement to comply with the DMA Contract, the DMH/DD/SAS Contract, and the requirements specified in this Scope of Work.

Minimum Requirements

To be considered by DHHS as an applicant to operate a PIHP and to participate in North Carolina's 1915 (b)/(c) Medicaid waiver, an LME must have a current contract with DHHS and must fully meet all of the minimum requirements shown in table 1.

These minimum requirements are viewed as necessary to meet North Carolina's goals for improved access, quality of services and cost benefit. For example, the requirement for the Medicaid eligible population size is necessary to provide the LME operating a PIHP with the minimally adequate funding to support Medicaid services, to make 1915 (b)(3) services available, and to establish the needed risk reserve as described below under Additional Requirements.

In order to fully meet the minimum requirements, an applying LME can propose a variety of organizational arrangements. Note that in table 1, the phrase "the LME applying to operate a PIHP" refers to any of the following organizational arrangements:

- A single LME.
- A merger of two of more LMEs. (Per G.S. 122C-115.3(a) a full merger can only become effective at the start of a new state fiscal year.)
- Various subcontracting arrangements among two or more LMEs.
- A management agreement among two or more LMEs.

DHHS may contract with a single LME, a merged LME or a lead LME. Therefore, under the options for a subcontracting arrangement or for a management agreement, note that DHHS will only contract with and make all State and Medicaid capitated funding payments to the lead LME designated in the application to operate the PIHP and manage state funded services.

Table 1. Minimum Requirements (Pass/Fail)
1. The LME applying to operate a PIHP has an unduplicated minimum Medicaid eligible population of 70,000 individuals ages 3 years and older. (See table 2 below)
2. The LME applying to operate a PIHP does not provide State funded or Medicaid reimbursable services (i.e., totally divested of all services at the date of application submission).
3. The LME applying to operate a PIHP is currently fully accredited for a minimum of three (3) years through an accrediting body approved by DHHS, AND agrees to become URAC or NCQA accredited by the end of the third year of operating the PIHP.
4. The LME applying to operate a PIHP has met the requirements to receive State service dollars through single stream funding.
5. The LME applying to operate a PIHP has financial resources sufficient to meet all requirements of the transition, implementation, and ongoing performance of all of the functions of a managed care organization, as evidenced by independent audits and other State financial records with no significant findings, by an adequate fund balance reserve to meet the requirements of this RFA, and by a letter of support from the full LME Board for assuming financial responsibility in submitting the application.

Table 1. Minimum Requirements (Pass/Fail)
6. The LME applying to operate a PIHP shall not serve as legal guardian for any recipient of Medicaid reimbursed mental health, developmental disabilities or substance abuse services.
7. The LME applying to operate a PIHP shall not contract with, or make any referral of a recipient to, any provider entity in which the LME or any member of the LME staff or a board member is an investor.
8. The LME applying to operate a PIHP shall maintain professional liability insurance for itself and its professional staff with limits of at least ($1,000,000) per occurrence and at least ($3,000,000) in the aggregate throughout the terms of the contract by the time the contracts are signed.
9. The LME applying to operate a PIHP must possess and maintain an automated management information system capable of performing all the activity, interfacing and reporting requirements of a managed care organization utilizing electronic data interchange using HIPAA transactions, including claims adjudication, third party coordination, eligibility maintenance, membership reconciliation, provider and fee schedule maintenance, capitation payment reconciliation, financial reporting and encounter data creation and submission. The system must have the ability for provider access to check the status of their service authorization requests, claims submission and claims payment status.
10. The LME applying to operate a PIHP shall provide letters of support from the Consumer and Family Advisory Committee (CFAC) of the LME that is submitting the application plus letters of support from any other CFACs that are part of the total configured population.
11. The LME applying to operate a PIHP agrees to abide by all requirements contained in this RFA and the DMA Contract and the DMH/DD/SAS Contract attached to this RFA, and any subsequent changes negotiated in future contracts or as required by the Centers for Medicare and Medicaid Services.

The decision to undertake the operation of a PIHP and to participate in the 1915 (b)/(c) waiver must be made with the agreement and support of an LME's Board and local Consumer and Family Advisory Committee (CFAC), as well as the support of each county included in the LME's catchment area. Likewise, the decision to participate in a new organizational arrangement will also involve each LME's Board and CFAC and affected counties. Letters of support from each confirm the understanding of responsibilities and support of all parties in this new endeavor. Note that in a merger or other multiple LME organizational arrangement, the counties are not required to be contiguous.

While the LME may propose to subcontract one or more functions required in the DMA Contract or the DMH/DD/SAS Contract, the LME may not contract out all waiver functions. Further, the applying LME may not contract out the roles and/or responsibilities of the LME Director or the Chief Finance Officer. The applying LME is responsible for all activities and must submit as part of its application all subcontracts in sufficient detail to demonstrate how the subcontracted function(s) will operate and be managed by the LME. Finally, the applying LME must meet the statutory requirements of NC General Statutes 122C Article 4, Part 2.

Note that DHHS will require consistency in the administration of the 1915 (b)/(c) waiver across the State through basic guidelines and requirements such as credentialing, utilization management, data management, reporting, performance measures, and other key functions. Following selection and announcement of the next LME(s) to participate in the 1915 (b)/(c) waiver, DMA, DMH/DD/SAS, PBH and the new LME(s) will collaborate to develop basic statewide guidelines and requirements.

For purposes of responding to this RFA, use table 2 to determine a LME's eligibility for meeting the first minimum requirement, i.e., an unduplicated minimum Medicaid eligible population of 70,000 individuals ages 3 years and older. Using this table, six LMEs as currently constituted meet the minimum Medicaid population requirement. To meet this minimum requirement, other LMEs may choose one of the alternative organizational arrangements described above with one LME applying as the lead.

Table 2. Medicaid Eligible Individuals July 2009 for RFA Waiver Application Minimum Requirement #1
Source: DMA's management information system, DRIVE Client-Population table, report date Jan 13, 2010.

Month	LME code	LME name	age=0-2	age=3-17	age=18-64	age=65-200	Grand Total	Requirement (Total less ages 0-2)
200907	101	SMOKY_MTN	11,388	31,914	33,666	12,941	89,909	78,521
	102	WESTERN_HIGHLANDS	11,009	29,680	31,512	10,480	82,681	71,672
	108	PATHWAYS	9,194	27,465	28,014	7,834	72,507	63,313
	109	CATAWBA	6,032	13,505	16,816	4,413	40,766	34,734
	110	MECKLENBURG	21,214	38,946	54,716	9,118	123,994	102,780
	112	PIEDMONT	16,390	35,013	44,978	10,479	106,860	90,470
	201	CROSSROADS	5,925	14,212	17,011	5,071	42,219	36,294
	202	CENTERPOINT	12,695	27,737	35,186	8,489	84,107	71,412
	204	GUILFORD	10,743	24,753	30,529	6,750	72,775	62,032
	205	ALAMANCE_CASWELL	4,270	9,134	11,429	3,389	28,222	23,952
	206	OPC	3,779	8,413	10,076	2,932	25,200	21,421
	207	DURHAM	6,862	13,318	16,303	2,811	39,294	32,432
	208	FIVE_COUNTY	6,249	20,808	19,541	6,956	53,554	47,305
	303	SANDHILLS	14,388	33,557	41,604	10,679	100,228	85,840
	304	SOUTHEASTERN_REG	9,384	28,539	29,335	8,656	75,914	66,530
	305	CUMBERLAND	7,391	21,516	22,982	3,862	55,751	48,360
	307	JOHNSTON	4,308	9,244	11,593	2,775	27,920	23,612
	308	WAKE	15,168	24,612	35,856	6,474	82,110	66,942
	401	SOUTHEASTERN	6,936	18,541	19,131	4,757	49,365	42,429
	402	ONSLOW_CARTERET	3,969	10,244	10,754	2,448	27,415	23,446
	405	BEACON	7,367	19,816	22,012	6,786	55,981	48,614
	407	ECBH	9,417	27,742	28,643	9,583	75,385	65,968
	412	ALBEMARLE	4,191	11,856	11,881	4,052	31,980	27,789
	413	EASTPOINTE	8,997	21,990	26,079	7,753	64,819	55,822
200907		Total	217,266	522,555	609,647	159,488	1,508,956	1,291,690

Additional Requirements

The pages that follow identify specific criteria the LME must meet and for which the LME must provide additional evidence in the application. The DMA Contract reference number associated with the requirements is given where applicable. Specific items the LME must address are included in this section of the RFA for ease of review by the Evaluation Committee. Note that the RFA does not request evidence for every item in the DMA Contract. However, if an applicant qualifies otherwise, all DMA Contract items along with those referenced in the RFA as determined by DHHS may be examined as part of an onsite review during the evaluation and selection process.

Also, note that the RFA uses terminology in accordance with CMS. Terms such as "care management" or "customer services" may differ from traditional usage in North Carolina; therefore, take care to check such definitions using the Definitions table provided in the Introduction.

Clinical Operations

DMA contract section Reference #	Clinical Operations

6.7
6.10
6.11
6.14
6.15
6.16
6.17
	Customer Services
	(Limit to 5 pages exclusive of the organization chart and sample enrollee education materials)
	
	The LME shall provide Enrollees with toll-free telephone access and emergency referral, either directly or through its Network Providers, twenty-four (24) hours per day, seven (7) days per week.
	• Provide a detailed organization chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing customer service functions.
	• Describe the educational and experience requirements for customer services staff and supervisors.
	• Describe the location of customer services operations and available resources, including the information technology to support customer services functions.
	• Describe the work flow process from time of first contact, triage, referral and access of appropriate services. Include the steps for linking calls to care managers.
	• Describe how enrollees are educated about benefits and services and provide a sample of educational materials. Include any evidence of education for enrollees on emergency services.
	• Describe your how website ensures ease of use by enrollees such as consumer friendly language and ADA compatibility.
	• Describe how emergency calls will be managed by customer services, during regular hours and during weekends or after hours. Address the following items:
	  • How it is determined that an emergency exists.
	  • How the caller is connected with an individual or service that can help him or her.
	  • Describe the interface with crisis services and 911/fire/rescue.
	  • Indicate the licensure requirements for those responsible for call resolution and required follow-up.
	• Describe how customer services will respond to calls related to grievances and appeals.
	• Describe the LME's training plan for customer service staff including approaches to assure consistency among staff in responding to calls.

DMA contract section Reference #	Clinical Operations
6.13 6.17 7.4	***Care Management/Utilization Management*** (Limit to 15 pages exclusive of the organizational chart) **The LME shall have a care management (CM)/utilization management (UM) program that is staffed by licensed professionals and is sufficient to meet the care coordination needs of the enrolled population.** • Describe how the care management/utilization management program will be organized. Provide a detailed organizational chart that identifies the number of FTEs, titles of each care manager/utilization management position and supervisors. • Describe the educational background and experience requirements for care management/utilization management staff and supervisors. Include a description of licensure requirements. • Describe the location of CM/UM operations for this Contract and available resources, including the information technology to support CM/UM functions. • Describe the care management process from the time the member or provider contacts the LME to request services through the time of first appointment. Address how the LME: ▪ Handles requests for services through the 24-hour access line. ▪ Matches enrollees to providers. ▪ Provides enrollees with real choice among the providers. ▪ Tracks and manages requests for out-of-network and out-of-region providers. ▪ Assures providers are accepting new referrals. ▪ Confirm the individual was seen in a timely manner. ▪ Conducts follow-up with individuals who do not show up for an appointment. ▪ Addresses and tracks requests to change providers. • Describe the LME's process for monitoring high risk and high cost consumers and individuals with special needs to ensure that all needs are addressed through clinically indicated services. • Describe the care management process for assisting enrollees choosing consumer directed care available under the Innovations waiver program. • Describe the LME's current efforts to assist consumers in overcoming barriers to services. Specifically address transportation, interpretation and coordination with community resources. Describe how these issues are addressed in staff training. • Describe how the LME will conduct the utilization management program. Address the following issues: ▪ Describe the ongoing monitoring protocols for utilization management staff. Include the nature and frequency of supervision, documentation of audits, call monitoring, and any other oversight activities. ▪ Describe the utilization management workflow and processes for authorization and denials of care, including the qualifications of the professionals that can deny care. ▪ Describe how the LME will use data and clinical decision support information systems to support care management activities. Specify the types of data used. ▪ Describe the methodology for identifying over- and under-utilization of services.

DMA contract section Reference #	Clinical Operations
	▪ Describe how the LME will provide an outreach program to ensure that high-risk mental health, developmental disabilities and substance abuse recipients understand the benefits and services available to them. ▪ Describe how the LME defines and identifies high-risk mental health, developmental disabilities and substance abuse recipients. ▪ Describe how the LME will obtain clinical advisory input from licensed mental health and substance use treatment professionals in the review of practice guidelines utilized for authorization of services. ▪ Describe the role of the LME Medical Director in working with Care Management and Utilization Management. • Describe the LME's clinical guidelines for medical necessity criteria and level of care determination guidelines. Address the following: ▪ List the source of the criteria/guidelines with which the LME has experience and indicate the LME's experience in utilizing guidelines. ▪ Describe the training provided to care managers, physician advisors and after-hours clinicians regarding the application of the criteria/guidelines in managing care. Include a plan for determining inter-rater reliability of medical necessity criteria application. ▪ Describe the process for assuring the criteria/guidelines are properly and consistently applied in the utilization review and care management process. ▪ Describe the transition process, gearing up staff process, and MIS process for providing UM for all Medicaid recipients within the region of the PIHP who receive mental health, developmental disabilities and substance abuse services within the region of the PIHP.
1.4-1.7 7. 7.1 7.5 Attachment M	***Quality Assurance and Quality Improvement*** (Limit 8 pages exclusive of organizational chart) **The LME shall provide a quality assurance and improvement program that supports increased access to services, improved outcomes and efficiency.** **Internal Quality Assurance/Performance Improvement Program:** • Describe how the LME ensures quality across all aspects of its internal operations and service area through the use of the CMS Quality Framework model. Specifically, describe how the LME will implement the four components of the model as listed below. Design: How will the LME structure roles, relations, and policies and procedures to support quality internally and in its relations with providers and consumers? • Provide a detailed organizational chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing quality management functions. • Describe the required qualifications for each position that will participate in the quality management program including licensure requirements. • Describe the location of QM and QI operations for this Contract and available

DMA contract section Reference #	Clinical Operations
	resources, including the information technology to support QM/QI functions. • Describe the essential elements of the LME's Quality Management Plan and how the applicant will assure that the plan is a dynamic document that focuses on continuous quality improvement activities. Include: ▪ Service delivery, administrative and clinical processes and functions to be addressed. ▪ Committee(s) structure, responsibility and membership. ▪ Necessary data sources. ▪ Proposed outcome measures and instruments. ▪ Monitoring activities (e.g., surveys, audits, studies, profiling, etc.). ▪ Feedback loops. ▪ QM program workflow, including how the QM Committee(s) structure coordinates with the utilization management program and client rights oversight. Discovery: How will the LME monitor internal and external operations at the individual and aggregate level to ensure effective management and a high quality service delivery system? • Describe how the LME monitors and conducts QA on a system-wide and individual case basis. • Describe how the QM program monitors, tracks and reports on applicable performance measures, performance guarantees and incentives. • Describe how the LME uses member and provider feedback (including the annual customer service satisfaction survey and complaints) and/or provider profiling to identify problems and improve service delivery. Remediation: How will the LME identify and address quality issues in its internal operations, its service provider agencies and its overall service delivery system? • Describe the method the LME will utilize to prevent, identify, and correct quality issues with contracted providers, including the role of QM in relation to provider network management. Improvement: How will the LME identify areas for improvement and implement and evaluate improvement initiatives? • Describe how the QM program will identify and prioritize areas for improvement • Describe how the QM program will utilize data to support quality improvement. Describe how the QM program will implement and evaluate improvement initiatives
	Enrollee Grievances and Appeals: • Recognizing that the LME must provide a system for Medicaid appeals, state separately, for each of the most recent two calendar years: • The number and types of complaints and grievances received from consumers. • The number and types of complaints and grievances resolved within thirty days. • Rank in order from the greatest to least, the three most common types of grievances received regarding your contracted providers. • Describe the staffing plan for the grievance system, including an organization chart and job descriptions, and staff resumes that describe pertinent experience and

DMA contract section Reference #	Clinical Operations
	certification/licensure. • Describe the orientation and education that will be given to the LME's staff that interact with enrollees and providers regarding the recognition and processing of enrollee grievances, complaints and Medicaid appeals. • Submit the policies and procedures that cover the process for ensuring decision makers about grievances and appeals have not been involved in previous levels of review of decision making. • Submit the policy and procedure that describes the assistance that will be provided to enrollees in completing the procedural steps in the complaints and grievance system. • Describe the consumer education materials that will be developed to explain the Medicaid appeal and the complaint and grievance systems.
6.8 6.18 7.4 7.6 7.7 7.8	***Provider Network Management*** (Limit 8 pages exclusive of organization chart, provider lists, and sample reports) **The LME shall provide a network management program that supports the needs of enrollees and includes the following functions: Provider relations, contracting, credentialing, development, profiling and training. The LME shall have a provider manual that outlines network participation requirements.** • Describe the LME's provider network management strategies to arrange for required covered services. • Provide a detailed organizational chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing network management functions. • Describe the required qualifications for each position that will participate in the network management program including licensure requirements. • Provide evidence that staff is representative of the population's ethnic and racial makeup according to the latest US Census Bureau data. • Describe the LME's plan in implementing cultural competency awareness and plan for the Provider Network to meet the demographic needs of the community population. • Describe the location of network operations for this Contract and available resources, including the information technology, to support network management functions, as well as use of encounter claims that identify providers. • Provide a listing of fully executed contracted providers by level of care and by zip code. • Describe the LME's continuum of crisis services. • Describe how the LME ensures choice of at least two providers for each service, noting approved exceptions for specialties. • Provide a listing and brief description of contracted culturally and linguistically appropriate services that address the needs of the diverse populations residing in the LME's service area. • Provide a listing and brief description of the contracted evidence based services and promising practices available in the LME's service area. • Provide a list of the gaps that exist in the proposed network and the LME's proposed

DMA contract section Reference #	Clinical Operations
	strategies to develop the network to close the gaps. • Describe the specific strategies the LME has used and will use to recruit and retain providers to assure the network will meet the needs of a diverse population for culturally appropriate care including enrollees with limited English proficiency. • Provide a description of how the LME will monitor the network's adequacy and sufficiency, including performance measures and evaluation methodologies. • Describe how the LME will manage providers to assist enrollees' use of the consumer-directed care option under the Innovations waiver. • Provide an outline of the provider manual. • Describe the transition process from an open provider network under the current Medicaid and DMHDDSAS funded system to a closed Provider Network and issuing new provider contracts as a PIHP for state funded and Medicaid providers. • Provide a one page description of the network transition of care plan that limits disruption and permits most members to continue treatment with their current providers.
6.5 6.6	**Appointment Availability:** • Describe how the LME will ensure that enrollee appointment access standards are met, including two (2) hours if need is emergent, 48 hours if need is urgent, and 14 calendar days if need is routine. • State separately for each of the most recent two (2) calendar years, the average number of days from the date of receipt of a request for an eligibility determination to the first appointment for a member. • Describe how the LME will address access for individuals who require services when they are outside the LME's catchment area (e.g., while traveling in North Carolina or when residing in a group home outside the LME's catchment area). **Appointment Wait Time:** • Describe how the LME ensures that providers meet the requirements regarding wait times for scheduled enrollee appointments, walk-ins, and emergences as specified in the DMA Contract. • Provide a sample report for LME appointment wait times.

Administrative Operations

DMA contract section reference #	Administrative Operations
	Disclosure of Information on Ownership and Control (Limit to 2 pages exclusive of disclosures) • Submit a list of current members and terms of the Board of Directors. • Submit a list of current members and terms of the local Consumer and Family Advisory Committee.
	Disclosure of Information on Business Transactions (Limit to 4 pages exclusive of disclosures) • Submit any disclosure as described in Attachment R of the DMA Contract. • Describe your internal controls and systems to account for contract related and non-contract related revenues and expenses and to prevent and detect fraud.

6.9	***Facilities and Organization***
	(Limit to 5 pages)
	
	The LME shall have facilities and an organizational structure that is sufficient to support the operations of the waiver program.
	
	• Identify the main place of business of the waiver entity where the majority of services described in the RFA will be provided. If there are multiple sites, describe the functions at each site and the approach to coordination of requirements specified in the RFA.
	• Submit an organizational chart to demonstrate that the LME meets the clinical, administrative and financial management positions required to perform the functions of the contract as specified below:
	  • One full time medical director holding an unencumbered North Carolina medical license and who is board certified in psychiatry.
	  • One full time contract manager with a minimum of at least seven years of management experience preferably in human service that will act as the primary contact to DHHS.
	  • One full time director of management information systems with a minimum of two years experience in data management for health care.
	  • One full time utilization review director that is a clinician licensed in North Carolina and has a minimum of five years utilization review and management experience in mental health, developmental disabilities and substance abuse care.

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	• One full time quality management director that is preferably a licensed clinician with at least five years recent quality management experience and two years managed care experience or experience in mental health, developmental disabilities and substance abuse care. • One full time customer services director with at least 5 years combined customer service, clinical and management experience. • One full time provider network director that is a licensed clinician that has at least five years combined clinical, network operations, provider relations and management experience. • One full time finance director with at least 7 years experience managing progressively larger budgets • For each position, attach current resume / curricula vitae, or documentation sufficient to evidence education and experience pertinent to the position. • For staff not yet hired, attach a job description with minimum requirements of the position. • Describe the LME's plan to hire or otherwise include consumers and family members in daily operations.
7.9	***Health Information System*** (Limit to 5 pages) • Describe the LME's management information system and submit documentation to support items listed in section 7.9 of the contract pertaining to the required Health Information System. Recommended items include system flow charts, policies and procedures, reports, training manuals and any other information that demonstrates the LME's capabilities. • Describe the LME's automated management information system and submit documentation that it is capable of performing all the activity, interfacing and reporting requirements of a managed care organization utilizing electronic data interchange using HIPAA transactions, including claims adjudication, third party coordination, eligibility maintenance, membership reconciliation, provider and fee schedule maintenance, capitation payment reconciliation, financial reporting and encounter data creation and submission, provider access to check the status of their service authorization requests, claims submission and claims payment status. • Describe the LME's ability to work with DHHS to test and implement a health information system in conjunction with the Provider Network for the collection and reporting of consumer health record information.
Section 8 8.1 8.2 8.3	***Records*** (Limit to 5 pages) **The LME shall assure that the standards for the establishment, maintenance and retention/disposition of clinical care records by the LME and network providers are**

DMA contract section reference #	Administrative Operations
	met according to the Records Management and Documentation Manual (APSM 45-2) and the Records Retention and Disposition Schedule for State and Area Facilities (APSM 10-3) and any ensuing updates thereof. The LME shall maintain all LME Administrative Records and other service management records in accordance with APSM 45-2 and APSM 10-3 and the terms of the DMA Contract and with all specifications for record keeping established by DMA for purposes of audit and program management. Where there are inconsistencies, the more stringent standard applies. **Clinical Records:** • Describe the content of records the LME maintains for providers, including consumer records. • Prepare for an on site review of LME records that demonstrate the process of authorizations and how medical necessity is documented. • Describe how the LME meets the requirement to maintain LME service management records according to APSM 45-2 and APSM 10-3. • Describe how the LME assures that providers maintain records in accordance with State policies. • Describe how the LME assists providers in maintaining adequate consumer records and provide evidence in 3 pages or less.
9.2	***Encounter Data and Claims*** (Limit to 3 pages) **The LME shall report encounters for all services provided.** • The LME shall provide as documentation a pictorial system flow of the process for creating encounter data. LME should include policies and procedures, reports and user documentation that are used in the encounter data process. • Describe and provide supporting documentation for creating and transmitting encounter data to DMA using the current HIPAA compliant 837 transaction format via secure FTP (File Transfer Protocol) • Describe and provide supporting documentation for reconciling any and all errors found during encounter claim processing by DMA's fiscal agent. • Submit written policies and procedures that have been formally adopted by the LME for ensuing system recoverability both for LME information systems and for those of subcontractors. • Submit written policies and procedures that have been formally adopted by the LME for providing primary and backup system for electronic submission of data to DMA and DMH/DD/SAS. • Submit written policies and procedures that have been formally adopted by the LME that address how LME information systems are used for utilization review and resource management. • Provide a description of internal controls regarding fraud and abuse. • Provide copies of submission reports that are generated during the encounter

DMA contract section reference #	Administrative Operations
	submission process, both from subcontractors to the LME and from the LME to DMA and DMH/DD/SAS. • Provide copies of all enrollment and eligibility reports that demonstrate accurate receipt, processing and reconciliation.
1.10 9.3 9.6 Attachment W	***Financial Reporting Requirements*** (Limit to 5 pages excluding the financial statements) **The LME shall submit financial reports that are timely, accurate, and complete.** • Provide a description of the LME's accounting and information system and the LME's ability to implement changes in reporting requirements or provide ad-hoc data requests as required by DMA. • Provide a copy of the LME's most current annual audit. • Provide the LME's Current Ratio = current assets / current liabilities. • Provide the LME's Defensive Interval = (cash + cash equivalents) / ((operating expense - non-cash expense) / (period being measured in days)). • Describe the LME's process for certifying financial records submitted as reports.
9.4 Attachment M	***Clinical Reporting Requirements*** (Limit to 3 pages) **The LME shall have a clinical reporting system that includes reports on utilization data, on performance measurements and on performance improvement projects sufficient to manage and improve services to enrollees.** • Describe how the management information system used by the LME creates clinical reports and explain the process for making changes to meet new reporting requirements. • Describe the LME's consumer outcomes data collection, tracking and utilization.
9.5	***Fraud and Abuse*** (Limit to 3 pages) **The LME shall adopt and implement policies and procedures to guard against fraud and abuse**. • Describe the process for identifying potential fraud and abuse.
Section 11 11.1	***Subcontracts*** (Limit to 3 pages) **The LME may enter into subcontracts for the performance of its administrative**

DMA contract section reference #	Administrative Operations
	functions and for the provision of covered services to enrollees. The LME shall obtain DHHS prior written approval before subcontracting any of its administrative or clinical functions. • Describe and provide transition plan for implementation of subcontractor function and give a detailed description of the scope of work, along with background reference checks of work performance and credibility of performance.
11.2	***Timeliness of Provider Payments*** (Limit to 5 pages) **The LME shall have evidence of the LME's history of prompt payment to providers.** • Describe the LME's provider payment history for the past three years.
Section 1.9 8.2	***Financial Management/Monitoring*** (Limit to 6 pages) **The LME shall have internal controls and systems in place to ensure that all Title XIX Medicaid revenue and expenditures are accounted for separately from other funding sources.** • Provide a description of the LME's internal controls and systems in place to ensure that all Title XIX Medicaid revenue and expenditures are accounted for separately from other funding sources. • Provide a description of the LME's process for calculating Incurred But Not Reported (IBNR). • Provide a description of the LME's process to monitor and track monthly capitation payments to ensure service delivery can be provided throughout the contract year. Within this description, describe the LME's budgeting process and methods to track actual expenditures against budgets. Describe the process as it relates to both Title XIX Medicaid and other funding sources. • Provide a description of the LME's process in place to demonstrate that all third-party resources are identified, pursued, and recorded. All funds recovered by the LME from third-party resources shall be treated as income. • Provide a description of how payments to providers by the LME shall be made on a timely basis, as required by section 11.2 of the contract. • Provide a plan as to how the LME will set up and manage the risk reserve.
Section 2	***Contractor Designated as a single PIHP*** (Limit to 2 pages exclusive of formal agreements) If other than a single LME applies, see the discussion in the Scope of Work and submit the following: • Definition of the geographical area and the business relationships formulated to act as

DMA contract section reference #	Administrative Operations
	a single PIHP. • Attached evidence of business affiliations and all formal agreements. • Describe and submit evidence of all community stakeholders engagement (consumers and families, CFAC, provider network, community and county agencies) in submitting this RFA application to the State. • Describe and demonstrate evidence of future and ongoing efforts to strengthen the collaborative partnerships with the LME operating a PIHP.
Section 4	***Enrollment and Disenrollment*** (Limit to 1 page) **The waiver entity shall have policies and procedures for facilitating information exchange with the local department of social services regarding enrollee participation in the Innovations Waiver 1915 (c).** • Discuss the policies and procedures in place to facilitate the exchange of information with the local department of social services regarding approvals for participation in the Comprehensive and Supports waivers.

Implementation Plan

(Limit to 15 pages)

The LME applying to operate a PIHP shall submit a project implementation plan that demonstrates the capacity to implement the requirements specified in the RFA. For purposes of the Implementation Plan, use January 1, 2011 as the start date, which is six months following the announcement of selection, with the understanding that is contingent upon approval by CMS of the technical amendment that specifies the selected LME.

- For each of the clinical and administrative section function areas described above, provide an implementation plan with sufficient detail to clearly articulate tasks, time frames, and expected results for each of the RFA requirements identified.
- Provide an index to your policy and procedural manual and draft policies that will support the activities of a LME operating as a PIHP and that can be reviewed onsite.

Pending Lawsuits and Judgments

(Limit 2 pages)

- Submit a statement that there have been no legal actions taken against the LME applying to operate a PIHP in the past two (2) years and there are no judgments or other legal actions pending;

OR,

- If any legal action has been taken, or is pending, provide an explanation.

CONTENT OF THE APPLICATION

Assemble the application ensuring that the following information is included in the following order.

1. Signed Transmittal Letter
2. Application Face Sheet (see appendix B)
3. Minimum Requirements Checklist
4. Financial Status and Viability
5. Application narrative addressing the requirements and questions in the order as requested in Scope of Work section of this RFA
6. Implementation plan
7. Appendices: Minimum Requirements documentation, applicable subcontracts and as otherwise required to support the application narrative

Number each page consecutively beginning with the Application Face Sheet. Provide one original and twelve (12) copies of the application. Use a binder clip at top left corner on each copy of the application or place in a notebook.

In addition, submit only the requested number of copies of specific items (such as the annual audit and financial statements) as attachments to the application.

Note that this RFA and the application will become part of the DMA Contract and the DMH/DD/SAS Contract. These contracts will be finalized prior to signature.

Minimum Qualifications for Participation (Pass/Fail)

Complete and submit the Minimum Requirements Checklist as provided in appendix C to confirm that the LME applying to operate a PIHP meets the minimum requirements of this RFA. Provide all the requested documents outlined in the minimum requirements in an appendix entitled Minimum Requirements Documentation. The checklist includes:

- First column - Requirements: The minimum organizational requirements that must be met by any potential LME for the administration of the 1915(b)/(c) waivers.

- Second column – Reference: The documentation in the DMA contract, the DHHS waiver technical amendment application submitted to CMS, or in this RFA of the details of the requirement listed.

- Third column – Location: The page numbers of the LME's application that addresses the requirement. For each requirement, insert required documentation in the appendix to the application and identify the appendix number in the third column. If other documents are referenced, provide the title(s) of the corresponding document(s) that address(es) the requirement and applicable page number(s). Attach copies of those referenced pages only in the appendix and identify the appendix number in the third column.

- Last column – Fully Met: A check mark here verifies the requirement is FULLY met by the LME.

Financial Status and Viability (Pass/Fail)

Submit the following information in an attachment to the application. See Section 1.3 of the DMA Contract.

- The LME shall provide three (3) copies each of its two most recent annual audits (SFY2008 and SFY2009) to verify its financial status, solvency, and viability. Annual financial statements should be audited in accordance with Generally Accepted Auditing Standards by an independent Certified Public Accountant (CPA) including all audit findings.
- The LME shall submit three (3) copies of all financial statements in accordance with Generally Accepted Accounting Principals (GAAP). Materials submitted must be sufficient to indicate the organizational stability and financial strength of the LME. These reports and statements must be prepared by an independent CPA and at a minimum include a Balance Sheet, Income and Expenditures Statement, and Statement of Cash Flow.
- If the LME is selected for an onsite visit, the LME shall provide to reviewers at that time evidence that the following pro forma financial statements for LME can be prepared on an accrual basis by month for the first three (3) years beginning with the first month of the proposed execution date of the DMA Contract including:
    - A statement of monthly revenue and expenses.
    - A monthly cash flow analysis.
    - A balance sheet.

EVALUATION OF APPLICATIONS

In accordance with RFA requirements, the award will be made to one or more LMEs whose application(s) are determined to be the most advantageous to the State in managing and administering the mental health, developmental disabilities and substance abuse programs and services as defined in the Scope of Work, the DMA Contract and DMH/DD/SAS Contract referenced in this RFA. Capitation rates shall not be a factor in the proposal evaluation as DHHS will negotiate the capitation rates with the successful LME based upon the population served and the requirements specified in the Scope of Work. The objective of the RFA is to select one or more LMEs to operate a PIHP that brings:

1. A proven track record with demonstrated success in operating as a local management entity (LME) as defined in N.C.G.S. 122C-116.

2. Demonstrated capacity to operate a managed care program as exemplified by:
    - A cohesive management structure that meets the requirements to contract with the State.
    - A flexible, responsive customer services approach that is highly ingrained in the organization and promotes 24-hour access to services.
    - Access to industry standard tools, technology, and expertise in mental health, developmental disabilities and substance abuse services.
    - A care management/utilization management (UM) program that is person-centered, emphasizes the principles of recovery and resilience and self-determination, and relies on a state of the art UM protocols and clinical practice guidelines.
    - A well developed quality management program that has sufficient clinical and technical leadership and data management capabilities to monitor and improve access, quality and efficiency of care.
    - A provider network management program that facilitates the development, support and monitoring of network providers for the delivery of mental health, developmental disabilities and substance abuse services provided to children, youth, families and adults.
    - Experience and demonstrated success in implementing program innovations that result in improved administrative and clinical outcomes, such as increased access to care by traditionally underserved populations of all ages, improved community tenure, mental health/developmental disabilities/substance abuse-physical health integration, and integrated assessment and service delivery for both co-occurring mental illness and substance use disorders and co-occurring mental illness and developmental disabilities.
    - Human resource and management support necessary to effectively recruit and retain clinical and administrative qualified professional staff.
    - A solvent and financially viable organization that has sufficient financial and administrative resources to implement and operate managed care functions specified in this RFA.
    - An automated management information system that is capable of performing all the activity, interfacing and reporting requirements utilizing electronic data interchange using HIPAA transactions.

3. Demonstrated capacity and a proven approach to managing systems of care that:
    - Rely on innovative approaches to address the diversity and cultures of the population served, including, at a minimum, contracts with culturally competent providers.
    - Identify and implement the preferences of individuals and families in the design of services and supports through development and utilization of person-centered planning.
    - Facilitate the development of consumer-operated programs and use of peer support, including consumer/family team approaches.

- Facilitate the development and utilization of natural supports.
- Facilitate the use of self-management and relapse prevention skills, support stable housing, and address the development and maintenance of healthy social networks and skills, employment, school performance or retirement activities.

4. Demonstrated capacity to implement the requirements specified in this RFA through a well-designed and detailed implementation plan that clearly articulates tasks, time frames, and expected results.

Initial Review

The State will review all applications submitted by the deadline specified in the RFA for format and completeness. If the applicant meets the formatting and minimum requirements listed herein, the State will continue to evaluate the application. The State at its sole discretion may request clarification of information throughout the proposal evaluation process.

Application Evaluation

The State shall conduct a comprehensive, confidential, fair and impartial evaluation of the applications received in response to this request. The State reserves the right to reject any and all applications.

An Evaluation Committee will evaluate and numerically score each application that the State has determined to be responsive to the requirements of this RFA. The Evaluation Committee will be responsible for the entire evaluation process, including reference checks of vendors that the LME may choose for subcontracting one or more functions. The State reserves the right to determine the composition of the committee and to designate subject matter experts to assist in the process. Other designated staff of DHHS may act as observers during the evaluation and selection process.

The Evaluation Committee will conduct a desk review of each application and recommend one or more LME(s) as finalist(s) whose application is deemed to be in the best interest of the State. The State will schedule an on-site review of the finalist(s). The State will provide finalist LME(s) at least one (1) week notice in advance of the site visit. The LME(s) shall assure that all key personnel and any individual(s) who will function as significant contact person(s) in performance of the proposed program will be available during the site visit.

Final scoring will include the findings of the site visit and the desk review. The Evaluation Committee will make final recommendations to the DHHS leadership for final selection.

Minimum Requirements

In the proposal evaluation phase, the Evaluation Committee will rate the applications submitted in response to this RFA based on the following criteria outlined in the next section and the weight assigned each criterion. An LME must meet the Minimum Requirements as specified above to be included in this part of this evaluation phase.

Evaluation Criteria

The Evaluation Committee will evaluate the LME's strengths, capabilities, and experience including corporate background, past and current projects, financial soundness, and performance history. The State

shall conduct reference checks of vendors to verify the accuracy of submitted materials and to ascertain the quality of past performance. The State reserves the right to pursue any references that may assist in completing the application evaluation process. Submission of the application establishes the LME's agreement for the State to make any contacts it deems necessary to confirm the organization's experience and performance.

Applications will be evaluated based upon the evaluation criteria and the associated scoring listed in the table below.

Criteria	**Score**
1. Meets Minimum Requirements and Financial Status and Viability	Pass/fail
2. **Clinical Operations** • Customer service • Care Management/Utilization management • Quality Assurance and Quality Improvement • Provider Network Management	35%
3. **Administrative Operations** • Financial Management • Disclosure of Information on Ownership and Control • Disclosure of Information on Business Transactions • Facilities and Organization • Information Technology and Reporting • Enrollment and Disenrollment • Records • Encounter Data • Reporting Requirements • Fraud and Abuse • Timeliness of Provider Payments	35%
4. **Implementation plan** • Tasks • Timelines • Expected results • Transition for implementation of subcontracted functions	30%

THE PROCUREMENT PROCESS

The following is a general description of the process by which one or more LME will be selected to complete the goals or objectives of this RFA.

All prospective LMEs are encouraged to attend the Bidder's Conference that will involve a presentation about the RFA and an opportunity to ask questions. The Bidder's Conference will be held on Thursday, March 4, 2010 from 2 p.m. to 5 p.m. Additional information about the Bidder's Conference is available on the websites for DMA at: http://www.ncdhhs.gov/dma/lme/MHWaiver.htm and for DMH/DD/SAS at: http://www.ncdhhs.gov/mhddsas/waiver/index.htm

Written questions concerning the RFA specifications will be received until 5:00 p.m. on Thursday, March 4, 2010 as specified on the cover sheet of this RFA. Send questions in writing via email to: RFA.Medicaidwaiver@dhhs.nc.gov. *A summary of all questions received by email and at the Bidder's Conference and their answers will be posted on the Division's web site by 5:00 p.m. on Wednesday, March 10, 2010 on the websites for DMA at: http://www.ncdhhs.gov/dma/lme/MHWaiver.htm and for DMH/DD/SAS at: http://www.ncdhhs.gov/mhddsas/waiver/index.htm*

Applications in one original and twelve (12) hard paper copies must be received from each applying LME. The original Application Face Sheet (see appendix B) must be signed and dated by an official authorized to bind the LME.

All applications must be received by the funding agency not later than the date and time specified on the cover sheet of the RFA. Faxed applications will not be accepted.

The date and time the applications are received from each responding LME will be logged in.

At their option, the Evaluation Committee may request additional information from any or all applicants for the purpose of clarification or to amplify the materials presented in any part of the application. However, LMEs are cautioned that the evaluators are not required to request clarification: therefore, all applications should be complete and reflect the most favorable terms available from the agency or organization.

Applications will be evaluated according to completeness, content, experience with similar projects, ability of the agency's or organization's staff, cost, etc. The selection of one LME does not mean that the other applications lacked merit, but that, all facts considered, the selected application(s) was deemed to provide the best service to the State.

LMEs are cautioned that this is a request for applications, and the funding agency reserves the unqualified right to reject any and all applications when such rejections are deemed to be in the best interest of the funding agency.

GENERAL INFORMATION ON SUBMITTING APPLICATIONS

1. Award or Rejection

All qualified applications will be evaluated and award made to that LME whose combination of budget and service capabilities are deemed to be in the best interest of the funding agency. The funding agency reserves the unqualified right to reject any or all offers if determined to be in its best interest. Successful applicants will be notified in July 2010.

2. Decline to Offer

N/A

3. Cost of Application Preparation

Any cost incurred by an LME in preparing or submitting an application is the LME's sole responsibility; the funding agency will not reimburse any LME for any pre-award costs incurred.

4. Elaborate Applications

Elaborate applications in the form of brochures or other presentations beyond that necessary to present a complete and effective application are not desired. It is preferred that all submittals meet the following requirements:

- All copies are printed double sided.
- The font used must be at least 11 point.
- All submittals and copies are printed on **recycled paper with a minimum post-consumer content of 30%** and indicate this information accordingly on the response.
- Unless absolutely necessary, all proposals and copies should **minimize or eliminate use of non-recyclable or non re-usable materials** such as plastic report covers, plastic dividers, vinyl sleeves, and GBC binding. Three ringed binders, paper clips, and staples are acceptable.
- Materials should be submitted in a format that allows for **easy removal and recycling** of paper materials.

5. Oral Explanations

The funding agency will not be bound by oral explanations or instructions given at any time during the competitive process or after awarding the contract.

6. Reference to Other Data

Only information that is received in response to this RFA will be evaluated; reference to information previously submitted will not suffice.

7. Titles

Titles and headings in this RFA and any subsequent RFA are for convenience only and shall have no binding force or effect.

8. Form of Application

Each application must be submitted on the form provided by the funding agency, and will be incorporated into the funding agency's Performance Agreement (contract).

9. Exceptions

All applications are subject to the terms and conditions outlined herein. All responses will be controlled by such terms and conditions. The attachment of other terms and condition by any agency and organization may be grounds for rejection of that agency or organization's application. Funded agencies and organizations specifically agree to the conditions set forth in the Performance Agreement (contract).

All proposals are subject to the terms and conditions outlined in the attached RFA as well as the DMA Contract and the DMH/DD/SAS Contract that accompanies this request and the 1915 b/c Medicaid Waiver applications submitted to CMS.

10. Advertising

In submitting its application, agencies and organizations agrees not to use the results therefrom or as part of any news release or commercial advertising without prior written approval of the funding agency.

11. Right to Submitted Material

All responses, inquiries, or correspondence relating to or in reference to the RFA, and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by the agency or organization will become the property of the funding agency when received.

12. Competitive Offer

Pursuant to the provision of G.S. 143-54, and under penalty of perjury, the signer of any application submitted in response to this RFA thereby certifies that this application has not been arrived at collusively or otherwise in violation of either Federal or North Carolina antitrust laws.

13. Agency and Organization's Representative

Each agency or organization shall submit with its application the name, address, and telephone number of the person(s) with authority to bind the agency or organization and answer questions or provide clarification concerning the application.

There must be a transmittal letter signed and dated by an official authorized to legally bind the LME. The LME shall submit with its application the name, USPS address, email address and telephone number of the person(s) with authority to bind the organization and answer questions or provide clarification concerning the proposal.

14. Subcontracting

Agencies and organizations may propose to subcontract portions of work provided that their applications clearly indicate the scope of the work to be subcontracted, and to whom. All information required about the prime grantee is also required for each proposed subcontractor.

15. Proprietary Information

Trade secrets or similar proprietary data which the agency or organization does not wish disclosed to other than personnel involved in the evaluation will be kept confidential to the extent permitted by NCAC TO1: 05B.1501 and G.S. 132-1.3 if identified as follows: Each page shall be identified in boldface at the top and bottom as "CONFIDENTIAL." Any section of the application that is to remain confidential shall also be so marked in boldface on the title page of that section.

16. Participation Encouraged

N/A

17. Contract

DMA and DMH/DD/SAS will issue contracts to the selected LME(s) that will include the RFA and the LME's application.

The contract may include assurances the successful applicant would be required to execute when signing the contract.

It will also include a Notice of Certain Reporting and Audit Requirements Form that addresses compliance with all rules and reporting requirements established by statute or administrative rule.

For all contracts that require a conflict of interest policy (required for all Private not for profit agency), the agency or organization must complete a Notarized Conflict of Interest Policy Statement and submit a copy of their conflict of interest policy. The Agency or organization can adopt page 2 as their conflict of interest policy or attach their current adopted policy.

Agencies or organizations receiving Federal funds would be required to execute a certification regarding Lobbying and Debarment, and if applicable a Drug Free Workplace Requirements and/or Environmental Tobacco Smoke assurance.

18. Liability

Neither the State of North Carolina, nor its employees, shall be responsible for any liability claims against the LME.

Appendix A: General Terms and Conditions

Relationships of the Parties

Independent Contractor: The Contractor is and shall be deemed to be an independent contractor in the performance of this contract and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The Contractor represents that it has, or shall secure at its own expense, all personnel required in performing the services under this agreement. Such employees shall not be employees of, or have any individual contractual relationship with, the Division.

Subcontracting: The Contractor shall not subcontract any of the work contemplated under this contract without prior written approval from the Division. Any approved subcontract shall be subject to all conditions of this contract. Only the subcontractors specified in the contract documents are to be considered approved upon award of the contract. The Division shall not be obligated to pay for any work performed by any unapproved subcontractor. The Contractor shall be responsible for the performance of all of its subcontractors.

Assignment: No assignment of the Contractor's obligations or the Contractor's right to receive payment hereunder shall be permitted. However, upon written request approved by the issuing purchasing authority, the State may:

(a) Forward the Contractor's payment check(s) directly to any person or entity designated by the Contractor, or
(b) Include any person or entity designated by Contractor as a joint payee on the Contractor's payment check(s).

In no event shall such approval and action obligate the State to anyone other than the Contractor and the Contractor shall remain responsible for fulfillment of all contract obligations.

Beneficiaries: Except as herein specifically provided otherwise, this contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Division and the named Contractor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Division and Contractor that any such person or entity, other than the Division or the Contractor, receiving services or benefits under this contract shall be deemed an incidental beneficiary only.

Indemnity and Insurance

Indemnification: The Contractor agrees to indemnify and hold harmless the Division, the State of North Carolina, and any of their officers, agents and employees, from any claims of third parties arising out of any act or omission of the Contractor in connection with the performance of this contract.

(a) **Insurance:** During the term of the contract, the Contractor shall provide, at its sole cost and expense, commercial insurance of such types and with such terms and limits as may be reasonably associated with the contract. At a minimum, the Contractor shall provide and maintain the following coverage and limits:
    (1) **Worker's Compensation Insurance**: The Contractor shall provide and maintain worker's compensation insurance, as required by the laws of the states in which its employees work, covering all of the Contractor's employees who are engaged in any work under the contract.
    (2) **Employer's Liability Insurance:** The Contractor shall provide employer's liability insurance, with minimum limits of $500,000.00, covering all of the Contractor's employees who are engaged in any work under the contract.
    (3) **Commercial General Liability Insurance**: The Contractor shall provide commercial general liability insurance on a comprehensive broad form on an occurrence basis with a minimum combined single limit of $1,000,000.00 for each occurrence.
    (4) **Automobile Liability Insurance**: The Contractor shall provide automobile liability insurance with a combined single limit of $500,000.00 for bodily injury and property damage; a limit of $500,000.00 for uninsured/under insured motorist coverage; and a limit of $2,000.00 for medical payment coverage. The Contractor shall provide this insurance for all automobiles that are:
        (A) owned by the Contractor and used in the performance of this contract;
        (B) hired by the Contractor and used in the performance of this contract; and
        (C) owned by Contractor's employees and used in performance of this contract ("non-owned vehicle insurance"). Non-owned vehicle insurance protects employers when employees use their personal

vehicles for work purposes. Non-owned vehicle insurance supplements, but does not replace, the car-owner's liability insurance.

The Contractor is not required to provide and maintain automobile liability insurance on any vehicle – owned, hired, or non-owned -- unless the vehicle is used in the performance of this contract.

(b) The insurance coverage minimums specified in subparagraph (a) are exclusive of defense costs.
(c) The Contractor understands and agrees that the insurance coverage minimums specified in subparagraph (a) are not limits, or caps, on the Contractor's liability or obligations under this contract.
(d) The Contractor may obtain a waiver of any one or more of the requirements in subparagraph (a) by demonstrating that it has insurance that provides protection that is equal to or greater than the coverage and limits specified in subparagraph (a). The Division shall be the sole judge of whether such a waiver should be granted.
(e) The Contractor may obtain a waiver of any one or more of the requirements in paragraph (a) by demonstrating that it is self-insured and that its self-insurance provides protection that is equal to or greater than the coverage and limits specified in subparagraph (a). The Division shall be the sole judge of whether such a waiver should be granted.
(f) Providing and maintaining the types and amounts of insurance or self-insurance specified in this paragraph is a material obligation of the Contractor and is of the essence of this contract.
(g) The Contractor shall only obtain insurance from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in the State of North Carolina. All such insurance shall meet all laws of the State of North Carolina.
(h) The Contractor shall comply at all times with all lawful terms and conditions of its insurance policies and all lawful requirements of its insurer.
(i) The Contractor shall require its subcontractors to comply with the requirements of this paragraph.
(j) The Contractor shall demonstrate its compliance with the requirements of this paragraph by submitting certificates of insurance to the Division before the Contractor begins work under this contract.

Default and Termination

Termination Without Cause: The Division may terminate this contract without cause by giving 30 days written notice to the Contractor.

Termination for Cause: If, through any cause, the Contractor shall fail to fulfill its obligations under this contract in a timely and proper manner, the Division shall have the right to terminate this contract by giving written notice to the Contractor and specifying the effective date thereof. In that event, all finished or unfinished deliverable items prepared by the Contractor under this contract shall, at the option of the Division, become its property and the Contractor shall be entitled to receive just and equitable compensation for any satisfactory work completed on such materials, minus any payment or compensation previously made. Notwithstanding the foregoing provision, the Contractor shall not be relieved of liability to the Division for damages sustained by the Division by virtue of the Contractor's breach of this agreement, and the Division may withhold any payment due the Contractor for the purpose of setoff until such time as the exact amount of damages due the Division from such breach can be determined. In case of default by the Contractor, without limiting any other remedies for breach available to it, the Division may procure the contract services from other sources and hold the Contractor responsible for any excess cost occasioned thereby. The filing of a petition for bankruptcy by the Contractor shall be an act of default under this contract.

Waiver of Default: Waiver by the Division of any default or breach in compliance with the terms of this contract by the Contractor shall not be deemed a waiver of any subsequent default or breach and shall not be construed to be modification of the terms of this contract unless stated to be such in writing, signed by an authorized representative of the Department and the Contractor and attached to the contract.

Availability of Funds: The parties to this contract agree and understand that the payment of the sums specified in this contract is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds for this purpose to the Division.

Force Majeure: Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations by any act of war, hostile foreign action, nuclear explosion, riot, strikes, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

Survival of Promises: All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.

Intellectual Property Rights

Copyrights and Ownership of Deliverables: All deliverable items produced pursuant to this contract are the exclusive property of the Division. The Contractor shall not assert a claim of copyright or other property interest in such deliverables.

Federal Intellectual Property Bankruptcy Protection Act: The Parties agree that the Division shall be entitled to all rights and benefits of the Federal Intellectual Property Bankruptcy Protection Act, Public Law 100-506, codified at 11 U.S.C. 365 (n) and any amendments thereto.

Compliance with Applicable Laws

Compliance with Laws: The Contractor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.

Equal Employment Opportunity: The Contractor shall comply with all federal and State laws relating to equal employment opportunity.

Health Insurance Portability and Accountability Act (HIPAA): The Contractor agrees that, if the Division determines that some or all of the activities within the scope of this contract are subject to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-91, as amended ("HIPAA"), or its implementing regulations, it will comply with the HIPAA requirements and will execute such agreements and practices as the Division may require to ensure compliance.

Executive Order # 24: "By Executive Order 24, issued by Governor Perdue, and N.C. G.S.§ 133-32, it is unlawful for any vendor or contractor (i.e. architect, bidder, contractor, construction manager, design professional, engineer, landlord, Applicant, seller, subcontractor, supplier, or vendor), to make gifts or to give favors to any State employee of the Governor's Cabinet Agencies (i.e., Administration, Commerce, Correction, Crime Control and Public Safety, Cultural Resources, Environment and Natural Resources, Health and Human Services, Juvenile Justice and Delinquency Prevention, Revenue, Transportation, and the Office of the Governor). This prohibition covers those vendors and contractors who have a contract with a governmental agency; or have performed under such a contract within the past year; or anticipate bidding on such a contract in the future.

For additional information regarding the specific requirements and exemptions, vendors and contractors are encouraged to review Executive Order 24 and G.S. Sec. 133-32.

Executive Order 24 also encouraged and invited other State Agencies to implement the requirements and prohibitions of the Executive Order to their agencies. Vendors and contractors should contact other State Agencies to determine if those agencies have adopted Executive Order 24."

Confidentiality

Confidentiality: Any information, data, instruments, documents, studies or reports given to or prepared or assembled by the Contractor under this agreement shall be kept as confidential and not divulged or made available to any individual or organization without the prior written approval of the Division. The Contractor acknowledges that in receiving, storing, processing or otherwise dealing with any confidential information it will safeguard and not further disclose the information except as otherwise provided in this contract.

Oversight

Access to Persons and Records: The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with General Statute 147-64.7. Additionally, as the State funding authority, the Department of Health and Human Services shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions.

Record Retention: Records shall not be destroyed, purged or disposed of without the express written consent of the Division. State basic records retention policy requires all grant records to be retained for a minimum of five years or until all audit exceptions have been resolved, whichever is longer. If the contract is subject to federal policy and regulations, record retention may be longer than five years since records must be retained for a period of three years following

submission of the final Federal Financial Status Report, if applicable, or three years following the submission of a revised final Federal Financial Status Report. Also, if any litigation, claim, negotiation, audit, disallowance action, or other action involving this Contract has been started before expiration of the five-year retention period described above, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular five-year period described above, whichever is later.

Warranties and Certifications

Date and Time Warranty: The Contractor warrants that the product(s) and service(s) furnished pursuant to this contract ("product" includes, without limitation, any piece of equipment, hardware, firmware, middleware, custom or commercial software, or internal components, subroutines, and interfaces therein) that perform any date and/or time data recognition function, calculation, or sequencing will support a four digit year format and will provide accurate date/time data and leap year calculations. This warranty shall survive the termination or expiration of this contract.

Certification Regarding Collection of Taxes: G.S. 143-59.1 bars the Secretary of Administration from entering into contracts with vendors that meet one of the conditions of G.S. 105-164.8(b) and yet refuse to collect use taxes on sales of tangible personal property to purchasers in North Carolina. The conditions include: (a) maintenance of a retail establishment or office; (b) presence of representatives in the State that solicit sales or transact business on behalf of the vendor; and (c) systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. The Contractor certifies that it and all of its affiliates (if any) collect all required taxes.

Miscellaneous

Choice of Law: The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties to this contract, are governed by the laws of North Carolina. The Contractor, by signing this contract, agrees and submits, solely for matters concerning this Contract, to the exclusive jurisdiction of the courts of North Carolina and agrees, solely for such purpose, that the exclusive venue for any legal proceedings shall be Wake County, North Carolina. The place of this contract and all transactions and agreements relating to it, and their situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.

Amendment: This contract may not be amended orally or by performance. Any amendment must be made in written form and executed by duly authorized representatives of the Division and the Contractor. The Purchase and Contract Divisions of the NC Department of Administration and the NC Department of Health and Human Services shall give prior approval to any amendment to a contract awarded through those offices.

Severability: In the event that a court of competent jurisdiction holds that a provision or requirement of this contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of this contract shall remain in full force and effect.

Headings: The Section and Paragraph headings in these General Terms and Conditions are not material parts of the agreement and should not be used to construe the meaning thereof.

Time of the Essence: Time is of the essence in the performance of this contract.

Key Personnel: The Contractor shall not replace any of the key personnel assigned to the performance of this contract without the prior written approval of the Division. The term "key personnel" includes any and all persons identified by as such in the contract documents and any other persons subsequently identified as key personnel by the written agreement of the parties.

Care of Property: The Contractor agrees that it shall be responsible for the proper custody and care of any property furnished to it for use in connection with the performance of this contract and will reimburse the Division for loss of, or damage to, such property. At the termination of this contract, the Contractor shall contact the Division for instructions as to the disposition of such property and shall comply with these instructions.

Travel Expenses: Reimbursement to the Contractor for travel mileage, meals, lodging and other travel expenses incurred in the performance of this contract shall not exceed the rates published in the applicable State rules. International travel shall not be reimbursed under this contract.

Sales/Use Tax Refunds: If eligible, the Contractor and all subcontractors shall: (a) ask the North Carolina Department of Revenue for a refund of all sales and use taxes paid by them in the performance of this contract, pursuant to G.S. 105-

164.14; and (b) exclude all refundable sales and use taxes from all reportable expenditures before the expenses are entered in their reimbursement reports.

Advertising: The Contractor shall not use the award of this contract as a part of any news release or commercial advertising.

Appendix B: Application Face Sheet

APPLICATION FACE SHEET

Legal Name of Agency: _____

Address: _____

_____

_____

(Include physical address if different from mailing address)

Telephone Number: _____

Fax Number: _____

Email Address: _____ Agency Web-address: _____

Agency Status: ( ) Non-Profit ( ) For Profit ( ) Governmental

Agency Federal Tax ID Number: _____

Agency's Financial Reporting Year (IRS Audit Cycle) _____ through _____

Name and Title of Person Authorized to sign Contracts: _____

Name of Program (s): _____

SERVICE DELIVERY SITE(S):

_____

_____

AREA TO BE SERVED: _____

The LME applying to operate a PIHP agrees to abide by all requirements contained in this RFA and the DMA Contract and the DMH/DD/SAS Contract attached to this RFA, and any subsequent changes negotiated in future contracts or as required by the Centers for Medicare and Medicaid Services.

_____ _____

LME Director **Date**

Appendix C: Minimum Requirements Checklist

REQUIREMENTS	REFERENCE	LOCATION	Ö
1. The LME applying to operate a PIHP has an unduplicated minimum Medicaid eligible population of 70,000 individuals ages 3 years and older.	Scope of Work: Minimum Requirements, table 2		
2. The LME applying to operate a PIHP does not provide State funded or Medicaid reimbursable services (i.e., totally divested of all services at the date of application submission). Submit a list of any services provided by the LME within the past three years and date(s) of divestiture. Include the name(s) of the agency(ies) to which the services were divested and a description of the bidding process. If these agencies no longer provide the services, provide an explanation.	Scope of Work: Minimum Requirements		
3. The LME applying to operate a PIHP is currently fully accredited for a minimum of three (3) years through an accrediting body approved by DHHS, AND agrees to become URAC or NCQA accredited by the end of the third year of operating the PIHP. *Accrediting Body*:_____ *Date of accreditation:* _____ If accreditation is currently in process: *Date of application:* _____ *Expected date of accreditation:*_____	Scope of Work: Minimum Requirements		
4. The LME applying to operate a PIHP has met the requirements to receive State service dollars through single stream funding.	Scope of Work: Minimum Requirements		
5. The LME applying to operate a PIHP has financial resources sufficient to meet all requirements of the transition, implementation, and ongoing performance of all of the functions of a managed care organization, as	DMA Contract, Sections 1.9 & 1.10		

REQUIREMENTS	REFERENCE	LOCATION	Ö
evidenced by independent audits and other State financial records with no significant findings, by an adequate fund balance reserve to meet the requirements of this RFA, and by a letter of support from the full LME Board for assuming financial responsibility in submitting the application. Submit three copies each of the LME's independent audits for SFY2008 and for SFY2009 with findings. Submit a Letter of Support from the LME Board. Submit current Ratio and Defensive Interval. Submit documentation of either: • Restricted insolvency protection risk reserve account. Describe how the account will be managed. OR • Insolvency insurance.	RFA, pp. 29, Financial Status & Viability		
6. The LME applying to operate a PIHP shall not serve as legal guardian for any recipient of Medicaid reimbursed mental health, developmental disabilities or substance abuse services. If the LME is currently the guardian for individuals who receive Medicaid services, submit a plan to transfer guardianship.	Scope of Work: Minimum Requirements		
7. The LME applying to operate a PIHP shall not contract with, or make any referral of a recipient to, any provider entity in which the LME or any member of the LME staff or a board member is an investor.	DMA Contract, Section 1.8		
8. The LME applying to operate a PIHP shall maintain professional liability insurance for itself and its professional staff with limits of at least ($1,000,000) per occurrence and at least ($3,000,000) in the aggregate throughout the terms of the contract by the time the contracts are signed. Submit copies of all current insurance certificates. Include one copy of each of medical malpractice, general liability, professional liability, fire/property, and workers compensation.	RFA, p. 37, Indemnity & Insurance		

REQUIREMENTS	REFERENCE	LOCATION	Ö
9. The LME applying to operate a PIHP must possess and maintain an automated management information system capable of performing all the activity, interfacing and reporting requirements of a managed care organization utilizing electronic data interchange using HIPAA transactions, including claims adjudication, third party coordination, eligibility maintenance, membership reconciliation, provider and fee schedule maintenance, capitation payment reconciliation, financial reporting and encounter data creation and submission. The system must have the ability for provider access to check the status of their service authorization requests, claims submission and claims payment status.	DMA Contract, Section 7.9		
10. The LME applying to operate a PIHP shall provide letters of support from the Consumer and Family Advisory Committee (CFAC) of the LME that is submitting the application plus letters of support from any other CFACs that are part of the total configured population.	Scope of Work: Minimum Requirements		
11. The LME applying to operate a PIHP agrees to abide by all requirements contained in this RFA and the DMA Contract and the DMH/DD/SAS Contract attached to this RFA, and any subsequent changes negotiated in future contracts or as required by the Centers for Medicare and Medicaid Services.	Application Face Sheet		